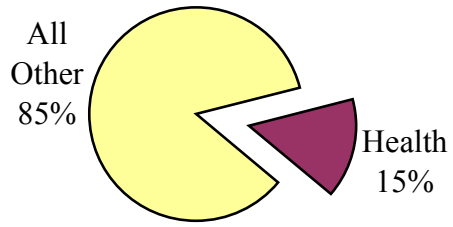
Health, Developmental Disabilities and Mental Health

HEALTH, DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH

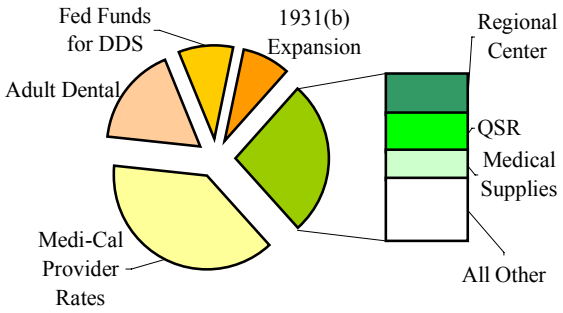
Graph 1

December Revision:
Reductions to Health Programs



Graph 2

Elements of Health Reductions



In this policy area, the December Revision includes reductions totaling over $1.5 billion over the two fiscal years, about 15 percent of the total revision, as displayed in Graph 1.

Graph 2 highlights the major aspects of the revision. As discussed in greater detail below, the reductions are primarily derived from the following actions:

- Reduce Medi-Cal provider rates for a savings of over $580 million.
- Eliminate eight Medi-Cal optional benefits, including Adult Dental and Medical Supplies. For the dental medical supplies reduction alone, the state would save $350 million over the next 18 month.
- Revert over $140 million (General Fund) from Developmental Services, as federal funds have increased to offset General Fund support.
- Rescind 1931(b) Medi-Cal eligibility for a savings of $124 million. This action reinstates the "100 hour a month work limit" for families with incomes up to about 61 percent of poverty.
- Reduce regional centers by $100 million.
- Reinstate quarterly status reporting (QSR) for families participating in Medi-Cal for savings of $90 million.

4120—EMERGENCY MEDICAL SERVICES AUTHORITY—
Consolidate with DHS
($138,000 BY)

Description. The Administration proposes adoption of trailer bill language in the Special Session to transfer the Emergency Medical Services Authority (EMSA) to the Department of Health Services (DHS) for savings of $138,000 (General Fund) in 2003-04.

Staff Comment and Alternative. The proposal seems reasonable but does not need to be enacted in the Special Session in order to obtain the minor savings. The legislation could proceed through the policy committee process if desired.

Additional state consolidation opportunities should be considered, particularly where there are departments with like functions. For example, the Office of Statewide Health Planning and Development could be a candidate for consolidation within the DHS as well.

4260--DEPARTMENT OF HEALTH SERVICES—The Medi-Cal Program

1. Reinstate Quarterly Status Report ($5 million CY & $85 million BY):

Description. The Administration proposes legislation to reinstate the Quarterly Status Report (QSR) effective April 1, 2003 *and* to change statute regarding the determination of Medi-Cal eligibility. Savings of $5 million (General Fund) in 2002-03 and $85 million (General Fund) in 2003-04 are estimated for this action. These savings estimates assume that 33,900 adults will be terminated from Medi-Cal coverage in 2002-03 and that 193,123 adults are dropped in 2003-04.

Under the QSR process, families participating in Med-Cal only (non-cash aid) are required to complete a detailed form about income and other personal information *every* three months (quarterly), even if there is no change in the families circumstance. Medi-Cal coverage is discontinued if the form is not promptly returned.

The Budget Act of 2000 eliminated the QSR process in favor of a streamlined system whereby families are required to self report within 10-days of any change in circumstance (such as a change in income). Elimination of the QSR reduced

administrative processing, maintained the families health care coverage, and simplified Medi-Cal to conform with the Healthy Families Program.

Prior to the elimination of the QSR, many Medi-Cal recipients were terminated from coverage even though they still qualified for services simply because they did not submit a QSR.

The Administration's proposed language would significantly erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. This aspect of the Administration's proposal goes beyond simply reinstating the QSR.

Chapter 1088, Statutes of 2000 (SB 87, Escutia), generally requires that in instances when Medi-Cal eligibility has been terminated on one basis, that a review must be conducted to determine if the individual is eligible for Medi-Cal under other circumstances. All avenues of potential Medi-Cal eligibility are to be reviewed to determine ongoing eligibility.

Staff Comment. Reinstatement of the QSR would achieve savings by terminating adults from Medi-Cal who are still likely eligible for Medi-Cal but simply did not return the QSR. The majority of recipients affected by this change would be adults (non-cash aid) enrolled in Medi-Cal managed care plans. However as discussed below, children could also be effected.

There are several analytical flaws with this proposal. First, these Medi-Cal recipients are very low-income wage earners—usually working people who have left CalWORKS and need medical coverage. Their circumstance is not likely going to change significantly and if it does, the recipient is required to report a change within 10 days. In addition, county eligibility offices can and often do monitor changes in Medi-Cal recipients' earnings using the state's automated wage reporting system; therefore, program eligibility can be checked prior to a recipients annual re-determination period.

Second, individuals dropped from Medi-Cal for not returning a QSR will likely seek medical assistance at county indigent health clinics or the emergency room. Safety net hospitals would lose Medi-Cal revenues and likely have to provide coverage to more uninsured.

Third, a key concern with this proposal is its interaction with the Administration's proposal to eliminate the 1931 (b) Medi-Cal eligibility category. If a Medi-Cal

recipient (adult, non-cash aid) does not return their QSR and is dropped from Medi-Cal, they likely will *not* be able to re-apply for Medi-Cal due to the elimination of the 1931 (b) category. This issue is discussed further in item two below.

Fourth, elimination of the QSR was intended to reduce over time Medi-Cal Administration costs in order to make the program more efficient and effective. Over the past two fiscal years, county Medi-Cal administration has been reduced by $459 million ($229 million General Fund) to reflect several cost reductions. If the QSR is reinstated, counties will need substantially more funding in order to re-program computer systems, train eligibility workers, and hire additional staff to process the additional paperwork. These increased county administration costs were *not* factored into the Administration's proposed savings amount.

Fifth, it would severely erode existing statute (SB 87, Statutes of 2000) by deeming Medi-Cal recipients who fail to return the QSR as being uncooperative and automatically terminated from benefits. As such, these individuals would not have their eligibility status reviewed by the county, nor would they be eligible to receive Transitional Medi-Cal Program coverage even if they would otherwise quality (low-income) for the benefits.

Sixth, 37 other states allow parents participating in Medicaid to annually renew their coverage. In fact, a federal review conducted of California in 2000 expressed grave concerns that a significant number of Medi-Cal recipients were losing coverage because the QSR was not being returned. In response to this criticism, the Davis Administration noted that it was eliminating the QSR requirement to facilitate the retention of families.

Further, there could be *unintended* consequences for children if this proposal is adopted. Many families apply to Medi-Cal as a family unit (parents and children). Subsequently, unless county computer systems are modified to distinguish between family members who are subject to the QSR and family members who are not, children could lose their Medi-Cal coverage inappropriately through a processing error. This is a realistic concern since a federal review conducted in California in 2001 found numerous inconsistencies in the operation of Medi-Cal computer systems across counties.

In addition, parents receiving a Medi-Cal termination notice may mistakenly believe that their entire family, including children, are being dropped from enrollment.

Pregnant women, CalWORKS-linked adults, and the aged, blind, and disabled Medi-Cal recipients are not affected by this QSR proposal.

2. Rescission of 1931 (b) Medi-Cal Eligibility ($6.2 million CY & $118 million BY)

Description. The Administration proposes legislation to rescind the 1931 (b) Medi-Cal eligibility expansion (currently at 100 percent of federal poverty) and to reinstate the "100-hour a month work limit". This proposal would limit eligibility to families with incomes up to about 61 percent of poverty (annual income of $11,041 for a family of four). With respect to employment, two-parent families would become *ineligible* for Medi-Cal if the principle wage earner works *more* than 100 hours a month (about 23 hours a week), no matter their low-income level.

The proposal assumes an April 1, 2003 implementation with savings of $12.4 million ($6.2 million General Fund) in 2002-03 and $235.9 million ($118 million General Fund) in 2003-04. These savings estimates assume that 58,578 adults will not be eligible for Medi-Cal coverage in 2002-03 and that 292,890 adults will not be eligible in 2003-04. After full implementation, the DOF estimates savings of $985.1 million ($492.6 million General Fund) annually.

Here are examples of how Medi-Cal eligibility would be changed, and made more complex, under this proposal:

- Two-parent working families applying for Medi-Cal where the primary wage earner works *more* than 100-hours per month will no longer qualify for Medi-Cal at *any* income level.
- Two-parent working families applying for Medi-Cal where the primary wage earner works *less* than 100-hours per month, will be eligible for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they would qualify for Medi-Cal under the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.
- Single-parent families and those two-parent families where one is disabled can qualify for the 1931 (b) category if their incomes are below 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify

for the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

- Families enrolled in Medi-Cal now (recipients) who rely on the applicant income test (families with unearned income, such as disability income) will only quality for the 1931 (b) category if their incomes are under 61 percent of poverty. If their incomes are between 61 percent and 75 percent, they qualify for the Medically Needy category. If there income is above 75 percent of poverty, they would qualify under the Medically Needy category with a share-of-cost.

The Budget Act of 2000 expanded eligibility for Medi-Cal to include families with income up to 100 percent of the federal poverty level. This action was in response to a federal Welfare Reform law change (Section 1931 (b) of the Social Security Act) which enabled states to grant Medicaid eligibility to anyone who would have met the income, resource and deprivation rules (such as children with an absent, decreased, incapacitated, or unemployed parent) of the AFDC Program as it existed on July 16, 1996 (date selected by Congress).

The concept behind this federal policy was to maintain health coverage for families that leave welfare for work, eliminate the incentive to be on welfare in order to receive health care coverage, and to make health care available for working, very low-income families.

Staff Comment. The Administration's proposal would deny health care coverage through the Medi-Cal Program to hundreds of thousands of low-income, working families. These are families which are low-income, *not* receiving cash-assistance, and who need health care coverage because their employers do not provide it.

As illustrated by the eligibility examples provided above, this proposed policy change serves as a *disincentive* to work full-time, to maintain family unity, and to move off of CalWORKS. Many families would not qualify for Medi-Cal even though they meet the low-income test because they are working more than 100-hours a month. If they lose health care coverage, they can spiral back into CalWORKS and potential poverty. If desired, the 1931 (b) eligibility category could be reduced *without* reinstating the 100 hour a month work limit.

Children are also affected by this proposal. While the proposed changes are intended to make more parents ineligible for Medi-Cal, the fact is that the entire

family loses coverage. The children would have to re-apply for eligibility under the Medi-Cal for Children Program (the 100 percent and 133 percent poverty programs).

This proposal also interacts with the Administration's proposal to reinstate the Quarterly Status Report (QSR). If an existing 1931 (b) category recipient loses Medi-Cal because they do not return their QSR, they are dropped from Medi-Cal and likely would *not* be eligible for Medi-Cal due to the elimination of the 1931 (b) category. This is particularly true for those who are working more than 100 hours a month.

This proposal also affects a families eligibility for Transitional Medi-Cal services. Currently when a family loses 1931 (b) eligibility because their income goes above 100 percent of poverty, they can still potentially obtain up to two years of coverage. The purpose of this federal law for transitional services is to assist families to move into self-sufficiency. However, families in the Medically Needy category are not eligible for Transitional Medi-Cal services. Subsequently families with incomes above 61 percent of poverty who will no longer qualify for 1931 (b) but will qualify for the Medically Needy category will *not* be eligible for Transitional Medical services.

The proposal would also require some families to pay a share of cost each month in order to obtain their Medi-Cal health care coverage. Families currently enrolled in the 1931 (b) program have no share of cost. Under the Administration's proposal families with incomes above 75 percent of poverty would have to pay a share of cost.

The proposal would also add additional complexity to Medi-Cal eligibility determinations. Changes to county computer systems, as well as county eligibility worker training, would be needed to implement this proposal. However the Administration's cost estimate does not take this into consideration.

3. Reduce by 10 Percent Provider Rates for Three Years ($90.4 million CY & $491.8 million BY)

Description. The Administration proposes legislation to reduce **both** Medi-Cal *and* non-Medi-Cal provider rates by 10 percent across-the-board effective April 1, 2003 to achieve savings of $90.4 million (General Fund) for 2002-03 and $491 million (General Fund) for 2003-04. The legislation would continue the reduction

for three years through 2005-06 (ending as of July 1, 2006). This is the first time that an across-the-board reduction has been proposed.

For Medi-Cal providers, the rate reduction **includes** nursing home facilities, Intermediate Care Facilities for Developmentally Disabled (ICF-DD), physician services, pharmacy, dental services, managed care plans, home health, medical transportation, and other medical services. This is the first time that nursing home facilities have been included in a rate reduction.

The rate reduction also includes non-Medi-Cal programs, including the California Children's Services (CCS) Program, the Family Planning, Access, Care and Treatment Program (Family PACT), the State-Only Family Planning Program, the Genetically Handicapped Persons Program, and the Breast and Cervical Cancer Early Detection Program. In addition, the Director of the DHS may also identify in regulations other programs in which providers shall be paid rates of payment that are identical to the rates paid under Medi-Cal.

The Administration's proposal does not include General Fund savings attributable to reducing the non-Medi-Cal programs. This was an oversight on their part and a figure is to be forthcoming in January. The figure is likely to be in the tens of millions of General Fund range.

Exempt from the reduction are: hospital inpatient services, hospital outpatient services, state operated facilities (*i.e.*, Developmental Centers and State Hospitals for the mentally ill), and Federally Qualified Health Centers/Rural Health Centers. Hospital inpatient services are exempt since the state negotiates inpatient services through the CMAC, and hospital outpatient services are addressed in the Orthopaedic Settlement Agreement. Federal law prohibits an across-the-board rate reduction for FQHC/RHC facilities since a cost-based or prospective payment system is used.

The following table summarizes the annualized reduction by Medi-Cal service category.

Medi-Cal Service Category	Total Fund Reduction	General Fund Reduction	Percent of Total Savings Level
Nursing Home Facilities (including ICF-DD)	$329.5 million	$168.8 million	34 percent
Managed Care Plans	278.6 million	139.3 million	29 percent
Physicians Services	94.4 million	51.1 million	10 percent
Other Services (adult day health, hospice, hearing aids, AIDS waiver, and others)	79.3 million	33.1 million	8 percent
Other Medical Services (podiatry, occupational therapy, acupuncture and others)	52.3 million	27.9 million	5 percent
Pharmacy Services	34.5 million	17.9 million	4 percent
ICF-DD Facilities	40.1 million	20.3 million	4 percent
Dental Services (adjusted for elimination of adult dental)	31.5 million	15.9 million	3 percent
Home Health	17.2 million	8.7 million	2 percent
Early Periodic Screening Diagnostic and Treatment (EPSDT) Services	2.7 million	1.3 million	< 1 percent
Medical Transportation	12.7 million	6.5 million	1 percent
TOTAL SAVINGS	**$972.8 million**	**$491 million**	**100 percent**

Staff Comment. There is some evidence that the rates paid to providers could affect access to health care and the quality of care to patients. A recent national analysis of Medicaid physician rates by The Urban Institute concluded that physician fee levels affect both access and outcomes for Medicaid patients.

In the Budget Act of 2000, most services provided under Medi-Cal received rate adjustments. This action was not an across-the-board rate increase, but instead

targeted services for which Medi-Cal physician rates were relatively low in comparison to the Medicare Program. Generally, other than annual adjustments for nursing home rates, there had not been a rate increase for most Medi-Cal services prior to the Budget Act of 2000 since 1986.

A PriceWaterhouse study completed last year found that, even after accounting for the rate increase provided in 2000, Medi-Cal rates continue to significantly lag behind those of other purchasers of health care coverage in California. The study found that Medi-Cal fee-for-service payment levels amounted to 35 percent to 60 percent of what private health care plans paid for the same services. Another study released last year found that while the 2000 Medi-Cal rate increases were substantial, they collectively only brought the Medi-Cal provider rates from 58 percent to 65 percent of California's average Medicare payment rates.

Inclusion of nursing homes in this reduction may be particularly problematic due to staffing standards and wage requirements, federal regulations, and the industry's dependence on Medi-Cal payments (two-thirds of the over 1,500 homes depend on Medi-Cal reimbursement). In addition, a State Plan amendment would be required since the federal government requires these rates to be developed on an annual basis through a methodology contained in the state's Medicaid State Plan.

Finally, it should be noted that during the budget deliberations of 2002-03, the Governor proposed to rescind the rate increase provided in the Budget Act of 2000; however this repeal was effectively denied by the Legislature on a bipartisan basis.

4. Proposed Elimination of Certain Medi-Cal Optional Benefits ($63.3 million CY & $274 million BY)

Description. The Administration proposes legislation effective April 1, 2003 to eliminate eight Medi-Cal benefit categories. The benefits slated for elimination are dental, medical supplies, podiatry, psychology, chiropractic, podiatry, acupuncture, and services provided by independent rehabilitation centers. Exempt from the proposal are services to children under 21 years of age, residents of long-term care facilities and persons with developmental disabilities. Federal law precludes the elimination of these services from these individuals.

The following table summarizes the reduction amounts.

Optional Benefit Category	2002-03 General Fund Savings (April 1, 2003)	2003-04 General Fund Savings (Annualized)	Percent of Total Savings Level
Adult Dental Services	$48.5 million	$211.8 million	77 percent
Medical Supplies (diabetic supplies, IV supplies, wound care, asthma supplies, contraceptive supplies)	12.9 million	54.3 million	20 percent
Podiatrist	995	4.3 million	2 percent
Acupuncture	666	2.9 million	1 percent
Psychologist	57	229	< 1 percent
Chiropractor	100	399	< 1 percent
Independent Rehabilitation Facility	5	23	< 1 percent
Occupational Therapy	4	15	< 1 percent
TOTAL GF SAVINGS	**$63.3 million**	**$274 million**	**100 percent**

Staff Comment. As noted above, the two categories of adult dental services and medical supplies account for 97 percent of the proposed savings. Denial of adult dental services or certain medical supplies such as asthma supplies will likely result in increased emergency room visits for pain and other medical services and subsequently, result in additional costs. In addition, there may be increased costs due to the delay in recipients receiving treatment and ultimately requiring more acute care services.

In the Budget Act of 2001, preventive periodontal services and periodontal treatment for pregnant women was added to the scope of Medi-Cal benefits at the direction of the Administration because it saves money by decreasing neonatal intensive care services. It has been well documented that periodontal disease affects the embryo, often causing pre-term low birth pre-term low birth weight babies. These services could *not* be provided if Adult Dental services are eliminated.

Further, in order to maintain some modicum of access for children's dental services, it has been argued that adult services need to be maintained in order to have a viable network of providers.

Alternatives. In lieu of eliminating these benefits, one could implement selective cost containment measures. For example, the adult dental benefit could be restructured to capitate the amount of service a recipient obtains.

In the Budget Act of 2002, the DHS was given the authority to contract for certain medical supply items which was estimated to save $9 million (General Fund) in 2002-03. It may be possible to include other medical supply items in this process to reduce expenditures and to even re-calculate how mark-up is determined for some incontinence supplies or related items.

5. Medi-Cal/Healthy Families Outreach ($168,000 CY & $4.3 million BY)

Description. The Administration proposes to eliminate training for certified application assistants in 2002-03 and to completely eliminate the Medi-Cal/Healthy Families Outreach Program completely as of July 1, 2003. Savings of $433,000 ($168,000 General Fund) are estimated for 2002-03 and $11.2 million ($4.3 million General Fund) for 2003-04. No trailer bill language is proposed or required, just a reduction to the appropriation.

For the past several years, the state has operated an Outreach Program to facilitate the enrollment of children into the Medi-Cal and Healthy Families programs. This effort has been successful in increasing enrollment, improving enrollment materials, and making the programs more family friendly and accessible. Key components of the Outreach Program have included the following:

- Allocation of grants to community-based organizations and schools to enroll eligible children;
- Payment of fees to application assistants to enroll eligible children;
- Dissemination of enrollment and education materials in multiple languages;
- Training of applicant assistants;
- Broadcasting of program advertisements on television and radio; and
- Availability of a toll-free line for interested families to call and ask questions.

Staff Comment. Though the Outreach Program has been successful, given the state's current fiscal condition, this is an area that can be reduced.

6. Intermediate Care Facilities for the Developmentally Disabled ($2.5 million CY & $10 million BY)

Description. The Administration proposes to enact legislation effective April 1, 2003 which requires ICF-DD facilities **and** state Developmental Centers to pay the state an assessment of 6.5 percent on the total rate per patient day. This assessment would then be used by the state to draw down matching federal funds. A portion of these new federal funds would be used to offset General Fund expenditures and to provide for a rate increase to ICF-DD facilities.

The Administration assumes total increased revenues of $5 million in the current year and $20 million annually. Of these new revenues, 75 percent would be provided back to these ICF-DD facilities as a provider rate increase. (In essence, this rate increase amounts to a pay back of the assessment fee plus half of the federal fund amount.) The remaining 25 percent of these funds would be used to offset $2.5 million (General Fund) for 2002-03 and $10 million (General Fund) for 2003-04.

It should be noted that the Administrations savings estimate will need to be modified. This is particularly true with respect to the state Developmental Centers (DCs) where no fiscal assumptions have yet been developed. According to the Administration, a number of issues need to be resolved before an accurate estimate can be provided for the DCs. For example, the DCs also serve some individuals who are not eligible for Medi-Cal—such as forensic residents. The tax could not be applied to these individuals.

In addition to the need for statutory change, the state would need to submit a Medicaid State Plan amendment to the federal CMS for approval. It should be noted that several other states have implemented similar programs for their ICF-DD populations.

Staff Comment. This is an excellent idea for the ICF-DD facilities for it enables the state to obtain additional federal funds and to use a portion of those funds to enhance the quality of care for individuals with developmental disabilities. It should be noted that ICF-DD facilities are almost 100 percent reliant on Medi-Cal funding and could equally benefit from the rate adjustment. The proposed

legislation may need to be slightly modified to ensure that the rate adjustment enhances services.

It should also be noted that the Administration has included ICF-DD facilities in their 10 percent Medi-Cal rate reduction proposal. As such, the rate increase proposed under this provider tax is significantly negated and the proposed General Fund savings estimate would need to be adjusted if the 10 percent rate reduction occurs.

With respect to the state Developmental Centers, additional information is needed on how the tax will be applied in order to assess the proposal. The Administration states that more information will be forthcoming at the May Revision.

7. Revision of Capital Debt from 2001 ($25.8 million General Fund)

Description. Existing law authorizes Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying hospital facilities. At the time of the Governor's May Revision, an estimate of reimbursement is made based on the most recent construction schedule available from the qualifying hospitals. This estimate is revised as necessary contingent on updated scheduling and debt payment.

The Administration proposes to revert $25.8 million (General Fund) from the 2001 capital debt reimbursement. This reversion is based on the most recent, updated capital debt needs as obtained from the participating hospitals.

Staff Comment. Based on the information provided by the DHS, it appears that the appropriation in the Budget Act of 2001 for this debt service is not fully needed and can be reverted.

4260--DEPARTMENT OF HEALTH SERVICES—Public Health & State Administration

1. Reduce Cancer Research Program ($6.250 million CY & $6.250 million BY)

Description. Chapters 755 and 756, Statutes of 1997 (AB 1554, Ortiz and SB 273, Burton), created the Cancer Research Act of 1997. From 1998 to 2001, the annual Budget Act provided $25 million (General Fund) for this program.

Due to fiscal constraints, the Budget Act of 2002 and accompanying legislation (1) reduced the appropriation level to $12.5 million (General Fund), (2) allowed for the receipt of private donations to the program, (3) capped the indirect costs for the grants at 25 percent, and (4) provided for multiple-year contracting for the grants.

The Administration proposes to reduce **both** the current year and budget year appropriations by 50 percent for a total proposed appropriation of $6.250 million (General Fund) annually. No statutory changes are proposed at this time.

Staff Comment. The Cancer Research Advisory Committee recently met and have ranked proposals received for the upcoming grant cycle (starting a new cycle). The ranking of the proposals was based on a $12.5 million appropriation level as provided for in the Budget Act of 2002. According to the DHS, if a reduction is enacted, the Committee can still use the same ranking method but fewer projects would be funded. Grants can be awarded for one to up to three years.

2. Reduce Prostate Cancer Treatment Program ($10 million CY & $10 million BY)

Description. The Administration proposes to reduce the Prostate Cancer Treatment Program by 50 percent, or $10 million (Tobacco Settlement Funds to be transferred to the General Fund), for both 2002-03 and 2003-04. They state that the reduction is due to lower than anticipated participation in the treatment program. No trailer bill language is proposed or required for this reduction to occur.

Under the Prostate Cancer Treatment Program, the DHS awards contracts to entities to provide cancer treatment for uninsured and underinsured men with

incomes at or below 200 percent of the federal poverty level. Treatment is provided for a period of up to 18 months.

Staff Comment. Estimated expenditures for this treatment program have always been several million less than anticipated due to lower caseloads than estimated through the annual budget process. The DHS contends that their revised expenditure estimate accounts for providing treatment to existing enrollees, as well as accounting for new enrollments. As such, this reduction seems reasonable.

3. Teen Pregnancy Prevention Media Reduction ($1.3 million CY)

Description. The Administration proposes to eliminate $1.9 million ($1.3 million General Fund) from unspent current-year contract funds slated for teen pregnancy prevention media. Of this proposed reduction amount, $900,000 is from media placement (radio and TV spots), and $1 million is from public relations.

No statutory changes are proposed.

Staff Comment. The existing contract contains $11.3 million (total funds) and is used for a wide variety of purposes related to teen pregnancy mitigation. The reduction amount proposed by the Administration is unspent. The Administration notes that the budget-year appropriation for this item is presently under discussion.

4. Reduce Domestic Violence Prevention Support and Technical Assistance ($400,000 CY one-time)

Description. The Administration proposes to delete $400,000 (General Fund) from a contract with the California State University at Sacramento for activities related to domestic violence prevention. These activities include data management, conference assistance and technical assistance provided to shelters.

Staff Comment. The DHS contends that state support from their office, as well as assistance from the OCJP, can be temporarily used in lieu of these contract funds.

5. Eliminate Valley Fever Vaccine ($350,000 CY & $700,000 BY)

Description. The Administration proposes to eliminate the Valley Fever Vaccine effective January 1, 2003 for savings of $350,000 (General Fund) in 2002-03 and $700,000 in 2003-04 (General Fund).

Staff Comment. Several organizations and at least one foundation are presently contributing about $1 million in private donations to this effort. As such, this adjustment seems reasonable.

6. Disencumber Prior Year Contracts ($10.1 million CY one-time)

Description. The Administration proposes to disencumber funds from prior budget appropriations in several areas. The primary area of reduction is for Quality Awards to nursing homes ($8 million from 2000-01, and $1.9 million from 2001-02) The purpose of these awards was to recognize individual health facilities for demonstrating a high level of quality of care in serving Medi-Cal patients.

Staff Comment. This program has never been implemented by the Administration. Funds for the program were eliminated in the Budget Act of 2002.

7. Eliminate Gynecologic Cancer Information Program ($150,000 CY & $150,000 BY)

Description. The Administration proposes legislation to eliminate this program and to delete the appropriation.

Chapter 754, Statutes of 1997 (AB 833, Ortiz) directed the DHS to place priority on providing information to consumers, patients and health care providers regarding women's gynecological cancer. The statute provides the DHS with flexibility to produce or contract with others to develop materials.

Staff Comment. Legislation eliminating the program is not needed even if the $150,000 (General Fund) appropriation is deleted. The existing statute is permissive and is contingent upon appropriation. Further, there may be other funding sources available for this project, such as foundation funds or federal funds.

8. Other Administrative Reductions ($322,000 CY & $ 382,000 BY)

Description. The Administration proposes to make other administrative reductions including the following:

Area of Reduction	2002-03	2003-04	Total GF
Out-of-State Travel	$140	$200	$340
Anti-Fraud Media	133	133	266
CALSTARS reporting	26	26	52
External Contracts (Audits & Investigations)	23	23	46
TOTALS	**$322**	**$382**	**$704**

Staff Comment. No issues have been raised for these items. It should be noted that the Out-Of-State-Travel line item reduction for 2003-04 only represents a 35 percent reduction.

4300--DEPARTMENT OF DEVELOPMENTAL SERVICES—Regional Centers

1. Proposed Implementation of Statewide Standards ($100 million BY)

Description. The Administration proposes legislation to implement statewide standards effective July 1, 2003 for the "purchase of services" conducted by the Regional Centers. This reduction would affect all adults and children with developmental disabilities participating in the Regional Center system whose services and supports are reduced or eliminated. The DOF assumes a reduction of $100 million (General Fund) in 2003-04 from this action.

The Administration is seeking approval of this legislation in the Special Session in order to achieve the full-year savings in the budget year. It represents a substantial change in policy, as discussed below under the comment section.

Though the language contains a sunset clause (inoperative as of July 1, 2006), it is very unlikely that the proposed policy contained in the language would change substantively after the sunset date since it represents such a fundamental difference in policy and potential expenditures.

The Regional Centers are responsible for providing a series of services to individuals with developmental disabilities, including purchasing services for consumers and their families based upon an "individual program plan". Individuals with developmental disabilities are legally entitled to receive services in California. The Regional Centers operate under contract with the state Department of Developmental Services (DDS).

As recognized in the Lanterman Act, differences in the purchase of services provided to individuals may occur across communities (Regional Center catchment areas) to reflect the individual needs of the consumers, the diversity of the regions which are being served, the availability and types of services overall, and access to "generic" services (i.e., services provided by other public agencies which are similar to those provided through a Regional Center).

Staff Comment and Alternative. Though the proposed language is referred to as establishing "statewide standards" for the purchase of services, the language does not function at all in this manner. It simply provides the DDS with broad reduction authority. For example, the language does *not* articulate any principles, process, or framework that would address what the standards would be nor how they would be applied on a statewide basis.

Instead, the proposed language grants very broad authority to the DDS to: (1) prohibit any consumer services or supports by type (such as Respite), (2) limit the type, duration, scope, location, amount, or intensity of *any* services and supports provided to consumers through the purchase of services by the Regional Centers, and (3) impose payment reductions and closure days on categories of vendors in order to insure that Regional Centers stay within their budgeted appropriation level.

In addition, the language explicitly states that consumers may *not* appeal a change in their services or supports if (1) the type of service or support has been prohibited through the actions of the DDS, or (2) the individual service or support has been reduced at the direction of the DDS in order to ensure that Regional Centers stay within their budgeted appropriation level.

Further, the language also states that vendors may not appeal a reduction in their payment or closure days as directed by the DDS.

The language also expresses that it is not the Legislature's intent to endanger a consumer's health or safety, nor place a consumer in a more restrictive setting in violation of the Olmstead Decision (1999, 527 U.S. 581). However, it is unclear how the DDS and RCs are to monitor this in order to assure something inappropriate does not occur.

The Administration has not provided any fiscal detail as to how the savings are to be achieved, because none exists. The savings figure simply assumes that the $52 million (General Fund) unallocated reduction taken in the Budget Act of 2002 is subsumed in the proposed statewide standards and that additional funds are obtained to achieve the round savings figure of $100 million.

In reviewing the 2000-01 actual expenditures for the Regional Center purchase of services line item, it is evident that $100 million in General Fund savings would be near impossible to achieve unless certain services are eliminated and provider rates in other service categories are reduced. This is because certain service categories—such as residential services and supported living—would be extremely difficult to reduce since these are fundamental services whose costs reflect staffing standard requirements, housing needs and basic amenities. These two service categories constitute 30 percent of expenditures for the purchase of services.

Other service categories such as Behavioral Services, Medical Care and Services, Medical Equipment and Supplies, and Therapy Services may be difficult to reduce for a reduction might endanger the health, safety and life of an individual. In addition, expenditures for these services are relatively small.

The other significant service categories include Adult Day Programs (22 percent of expenditures), Respite Services (7 percent), Transportation Services (7 percent), and Infant Development Services (4 percent). After the Residential Services category, these services reflect the highest expenditures.

Finally, there are some very small categories, such as Social Recreational Activities and Camp Services; however, these expenditures are relatively minor so their elimination would not amount to much savings.

Given the nature of the above outlined expenditures, it is likely that a significant level of the Administration's proposed reduction would need to come from Adult Day Programs, Respite, Transportation and some more minor cost areas such as Social Recreational Activities.

If purchase of service reductions are to be enacted, it is recommended to completely re-craft the language to establish a more comprehensive framework for service determinations, including stakeholder community participation, and to establish a more reasonable savings level that recognizes the need to not reduce certain core services.

In addition, it is feasible to expand the Home and Community-Based Waiver to include more service categories in order to obtain increased federal funding. Currently, the state is claiming federal funds for about 24 services; however, additional service categories such as certain Respite Services, Habilitative Supports, some Education Services, and additional Transportation Services could potentially also be claimed. Many of these services have been included in other states' waivers that have been approved by the federal government. Conceivably, $50 million or more could be obtained on an annual basis.

An expansion of the Waiver to include additional services would require some administrative work, including a Waiver amendment, a State Plan Amendment and some vendor billing modifications. No statutory changes would be required.

2. Increased Federal Funds Available To Backfill for General Fund ($142.7 million reversion for 2001-02)

Description. The Administration proposes to use $142.7 million in increased federal reimbursements to be obtained through the Home and Community-Based Waiver for 2001-02 (past year) as well as other federal fund sources to backfill for General Fund support. These increased federal funds are mainly attributable to adding about 9,000 new persons to the Waiver for the period from April 1 to June 30, 2002 (the end of the last quarter of the 2001-02 fiscal year).

This action does not require trailer bill language, just an adjustment to the appropriation level.

It should be noted that federal fund estimates for this area for 2002-03 and 2003-04 will be updated by the Administration in the January 10th budget release.

Under this Waiver, California can offer "nonmedical" services to individuals with developmental disabilities living in community settings who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility, or related conditions. Use of these "waiver services", such as assistance with daily living skills and day program habilitation, enable people to live in less restrictive environments such as in their home.

The Waiver has allowed the state to conserve General Fund dollars by shifting Medicaid (Medi-Cal) eligible beneficiaries to Waiver services while granting flexibility and assisting the state in complying with the Coffelt Settlement and the Olmstead Decision.

Staff Comment and Alternative. This is a reasonable assumption.

The DDS and Regional Centers have done a good job in expanding the receipt of federal funds, particularly with the Wavier. Further Waiver expansion will occur in the budget year as the Waiver cap expands to include 46,447 individuals, or about 1,400 more people than before.

In addition, other federal funding opportunities exist that could achieve tens of millions in federal funds annually. There is potential to obtain more federal funding through a variety of mechanisms, including modifying the Waiver (see issue 1, above), recalculating Targeted Case Management rates used by Regional Centers, claiming federal funds for certain Regional Center operations functions, and related items.

The DDS has been investigating these options as well as others. Most of these options would require federal approval through Medicaid (Medi-Cal) State Plan Amendments and in some cases, Waiver amendments. Further, some system modifications in the areas of vendor billing, Regional Center billing, and the like would need to be thought through and completed.

4300--DEPARTMENT OF DEVELOPMENTAL SERVICES— State Developmental Centers and Administration

1. Current Year Population Adjustment ($1.3 million CY)

Description. The Administration proposes to reduce by $2.3 million ($1.3 million General Fund) and 85 positions in 2002-03 due to an adjustment in resident population at the Developmental Centers (DC). Specifically, the current-year has been consistently below the estimated budgeted population for the past five months (July 1 through November 30).

Using the existing staff-to-resident methodology, a reversion of $2.3 million ($1.3 million General Fund) can be obtained. The primary savings from this proposal comes from not filling 85 authorized positions because they are not needed due to the revised population estimate.

This action does not require trailer bill language, just an adjustment to the appropriation level. Though a reversion of these funds would occur on the natural when the current-year is closed, legislative action can be taken prior to June 15th in order to recognize the savings level in a more timely manner.

Staff Comment & Alternative. Historically, savings due to reduced caseload in the DCs has been transferred to the Regional Centers in order to have the funding in essence, "follow the client". However, the proposed mid-year adjustments are proposing to address the Regional Centers separately. As such, this proposed DC adjustment seems reasonable.

In addition to this adjustment, consideration of closing Agnews DC (440 residents located in San Jose) should be considered. Closure of a DC typically takes two fiscal years in order to appropriate plan the closure and to transition individuals to other appropriate living arrangements using an individualized, person-centered process. Therefore if closure is to be pursued, planning needs to commence in 2003-04. Tens of millions in General Fund could be booked to reflect the sale of the Agnews property as well.

2. Porterville Air Conditioner in Kitchen ($1 million CY)

Description. The Budget Act of 1999 provided $1 million (General Fund) for the construction phase of installing an air conditioner in the main kitchen at Porterville Developmental Center (in Porterville). The Administration proposes to revert these funds which have not been expended.

This action does not require trailer bill language, just an adjustment to the appropriation level. Though a reversion of these funds could occur on the natural when the current-year is closed, legislative action can be taken prior to June 15th in order to recognize the savings level in a more timely manner.

Staff Comment. This proposed DC adjustment seems reasonable.

4440 DEPARTMENT OF MENTAL HEALTH—Community Mental Health

1. State Reduction to Mental Health Managed Care County Allocation ($4 million CY & $22.7 million BY)

Description. The Administration proposes to reduce the state's General Fund support of Mental Health Managed Care by reducing provider rates by 10 percent to save $4 million in 2002-03 and $22.7 million in 2003-04.

However in effect, this proposed reduction is *not* a provider rate decrease at all. Instead, the proposal represents a 10 percent reduction to the state's General Fund allocation to the counties, coupled with not funding the annual medical consumer price index (CPI) adjustment for Mental Health Managed Care.

Their proposal assumes an April 1, 2003 implementation for the 10 percent reduction (one quarter of 2002-03) with the reduction continuing into 2003-04. No trailer bill language is proposed for this 10 percent adjustment.

With respect to the medical CPI piece, the state has not provided this funding to counties since the Budget Act of 2000; therefore, no current year action is required. The proposed 2003-04 reduction would not require trailer bill legislation.

This proposed action would affect both inpatient and outpatient services for adults and children with severe mental illness.

The state's Mental Health Managed Care Program operates under a federal waiver whereby County Mental Health Plans are responsible for the provision of public mental health services, including those for Medi-Cal recipients.

Under this model the County Mental Health Plans, through a system of contracts with the state, are at risk for the state matching funds for services provided to Medi-Cal recipients. An annual state General Fund allocation is provided to County Mental Health Plans for this purpose, though counties also use County Realignment funds to draw down federal matching dollars.

The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index for medical services, and other relevant cost items.

Staff Comment and Alternative. Both the short-term and long-term effect of this action is to cost shift mental health services to the counties. This proposal continues the Administration's direction to substantially reduce General Fund support for mental health services, other than the State Hospitals. About $164 million (General Fund), or 34 percent of the General Fund, was reduced from community-based mental health services in the Budget Act of 2002.

The proposed reduction will likely result in County Mental Health Plans serving fewer individuals and having difficulty in meeting statutory and contractual responsibilities related to the provision of Mental Health Managed Care services.

In fact, the state and counties are having difficulty in presently meeting needs and requirements. As noted in the Independent Assessment of California's Mental Health Managed Care Program, prepared by the Department of Finance (May 2002 and released November 2002), the state needs to address numerous issues regarding client access to services, quality of services, performance outcome measures, and program management functions.

Another report—Psychiatric Hospital Beds in California: Reduced Numbers Create Potential Crisis (prepared by the California Institute for Mental Health, August 2001), discusses the significant shortfall of inpatient psychiatric beds in

California, as well as the lack of adequate capacity of the existing mental health system to provide alternative care for those clients in need of urgent care.

In addition, County Mental Health Plans are already providing a sizable amount of funding for Mental Health Managed Care. Based on the most recent estimate of expenditure data for 2001-02, of California's share of cost for Mental Health Managed Care, County Mental Health Plans provided a 46 percent match while the state provided a 54 percent match. Clearly, counties are presently using a substantial portion of their County Realignment Funds for this purpose, and due to the reductions from the Budget Act of 2002, will need to be using even more.

With respect to alternatives, there may be opportunities to obtain additional federal funds. First, the DMH could be directed to analyze the feasibility of expanding California's Home and Community-Based Waiver to include mental health services (Also see DDS discussion, above, regarding this Waiver). Chapter 887, Statutes of 2002 (SB 1911, Ortiz), directed the DMH to conduct this analysis contingent on receipt of funding for this purpose. However given this fiscal environment, the DMH should be proceeding with this anyway.

Second, the DMH should also investigate whether California can obtain additional federal funds through the Medicaid Rehabilitation Option. Under this federal option, implemented in 1993, California has been able to draw down hundreds of millions in increased federal reimbursement. It is likely that some existing services could be included in this option in order to draw down additional federal funds.

2. Eliminate the Early Mental Health Program ($549,000 CY & $15 million BY)

Description. The Administration proposes to revert $549,000 (Proposition 98 General Fund) in unexpended funds in 2002-03 and to eliminate the program in 2003-04 for savings of $15 million (Proposition 98 General Fund).

With respect to 2002-03, this action does not require trailer bill language, just an adjustment to the appropriation level.

With respect to 2003-04, though the Administration has proposed to eliminate funding, they have not as yet proposed to eliminate the program statute. Technically, the statute does not have to be stricken since the program is contingent upon appropriation in the Budget Act.

Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program.

In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

Staff Comment. This proposal continues the Administration's direction to substantially reduce General Fund support for children's mental health services. In the Budget Act of 2002, the Governor reduced by over $100 million a variety of areas that serve children with severe mental illness, including reductions to the Children's System of Care Program, the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Program, and services to special education pupils.

The Early Mental Health Initiative is an effective school-based program. It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs.

Both the short-term and long-term effect of this reduction is that children with mild to moderate school adjustment problems will likely not receive services and may, as a consequence, need more intensive services later. Further, these students may end up doing poorly in school and developing other problems.

3. Second Level Treatment Authorization Request (TAR) Appeals ($64,000 CY & $146,000 BY)

Description. The Administration proposes to eliminate the second level Treatment Authorization Request (TAR) appeals process for savings of $64,000 (General Fund) in 2002-03 and $126,000 (General Fund) in 2003-04. The savings comes from the elimination of 1.9 state positions. No trailer bill language has been proposed for this action.

Existing state regulation (Title 9, Section 1850.305) provides that a psychiatric hospital may file a second level TAR appeal when payment issues have not been resolved at the first level appeal (between the hospital and a County Mental Health Plan).

Typically, a second level TAR appeal involves disagreements between a hospital (non-county owned or operated facility) and a County Mental Health Plan regarding the number of bed days the county will reimburse.

For example, a hospital claims 15 days of inpatient services for a particular client and the County Mental Health Plan will only approve 10 days. As such, the hospital appeals the additional 5 days to the state. The state can either agree or disagree with the hospital. According to DMH statistics, the DMH agrees with County Mental Health Plans about 88 percent of the time.

It should also be noted, that the DMH's role in the second level TAR appeals process has inserted the department into judicial disputes between hospitals and County Mental Health Plans. According to the DMH, 29 lawsuits have been filed in this area.

Staff Comment. The proposal continues the Administration's direction to further reduce the state's role in providing oversight of mental health services. In this case, oversight of inpatient hospital psychiatric services.

County Mental Health Plans are concerned about this proposal because hospitals who want to appeal a County Mental Health Plan denial of payment can go directly to the courts, and the DMH would no longer be involved in the case.

This is really a policy area that needs to be clarified more, rather than a fiscal, budgetary issue. Broader policy issues exist that affect the provision of inpatient psychiatric services and the payment for them.

With respect to the fiscal issue, the hospitals and/or County Mental Health Plans could reimburse the state for the workload associated with the 1.9 positions currently used by the DMH.

4. Amend Protocols for Mentally Disordered Offender Evaluations ($300,000 CY & $300,000 BY)

Description. The California Department of Corrections refers inmates who are near their parole dates and potentially meet "mentally disorder offender" criteria to the DMH for clinical mental health evaluation. These evaluations are typically performed by contract psychologists or psychiatrists. Inmates are often referred to the DMH more than once if their parole is revoked, institution location changes or their parole date changes subsequent to their initial referral.

The Administration proposes to reduce by $300,000 in both 2002-03 and 2003-04 by implementing secondary review protocols. Specifically, these protocols will identify repeat referrals from the CDC where the clinical evaluation has already been done and found that either (1) the inmate does not meet mentally disorder offender criteria, or (2) there has been no change in the inmate's mental health or criminal profile to make the prior evaluation invalid.

No trailer bill language is required for this proposal.

Staff Comment. The proposal seems reasonable in that it avoids unnecessary repeat evaluations.

5. Other Administrative Reductions ($869,000 CY & $387,000 BY)

Description. The Administration proposes to make other administrative reductions including the following:

Area of Reduction	2002-03	2003-04	Total GF
Out-of-State Travel	$17	$37	$54
Transfer Children's System of Care technical assistance center to counties	350	350	700
Reduce HIPAA Funding	270		270
Reduce funding for Preadmission Screening & Resident Reviews for Mental Illness Activities due to late start.	232		232
Totals	**$869**	**$387**	**$1.3 million**

Staff Comment. These adjustments are reasonable.

ALTERNATIVE

The Legislature may also wish to consider a proposal to change the basis by which the state accounts for Medi-Cal payments. By changing its accounting practices the state could accrue savings of $1.2 billion on a one-time basis.

Summary. This proposal would require the Department of Health Services (DHS) and the Department of Finance (DoF) to change the accounting system for the Medi-Cal program from an accrual to a cash basis. In addition, the proposal would include legislation to authorize the Medi-Cal Providers Interim Payment Fund to pay Medi-Cal providers during any portion of the last quarter of any fiscal year in which a General Fund deficiency exists for the Medi-Cal program. This legislation would also appropriate up to $3 billion from the General Fund and up to $3 billion from the Federal Trust Fund, in the form of loans, to the Medi-Cal Providers Interim Payment Fund when such a deficiency exists.

Existing law. Currently, the Medi-Cal program is budgeted on an accrual basis, which means that claims for provider services rendered during a fiscal year are paid out of funding for that specific year, even if they are received after the end of that fiscal year. Funding for the payment of claims received after the end of the fiscal year must be included in the original budget for that year.

Section 16531.1 of the Government Code created the Medi-Cal Providers Interim Payment Fund for the purposes of paying Medi-Cal providers, providers of drug treatment services for HIV patients and providers of developmentally disabled services, during any portion of a fiscal year, prior to September 1 of that year, in which a budget has not yet been enacted. This Section also appropriates up to $1 billion from the General Fund and up to $1 billion from the Federal Trust Fund, in the form of loans, for these purposes. Loans are repaid automatically from the next year's Medi-Cal appropriations.

The proposal:

1. Requires DHS and DoF to change the basis for the accounting of the Medi-Cal program from accrual to cash, which means that claims for provider services rendered during a prior fiscal year would be paid out of the budget for the fiscal year in which they are received and paid. This would eliminate the need for including funding for the payment of claims received after the end of the fiscal year in future budgets, resulting in a one-time savings in the fiscal year the change is made.

2. Includes amendments to Section 16531.1 of the Government code to expand the purposes of the Medi-Cal Providers Interim Payment Fund to include payment of Medi-Cal providers in any fiscal year when a deficiency in General Fund appropriations exists during the last quarter of that year. These amendments would include appropriations of up to $3 billion from the General Fund and up to $3 billion from the Federal Trust Fund, in the form of loans, for this new purpose. These loans would similarly be repaid from the next fiscal year's Medi-Cal appropriations.

Fiscal estimate. Last year DHS estimated that the change from accrual to cash for Medi-Cal would result in a one-time reduction of the need to budget approximately $1.2 billion General Fund, thereby reducing the overall deficit by a similar amount. However, it should be noted that if the accounting system were ever shifted back to an accrual basis there would most likely be some one-time costs associated with

that shift, as well. DHS is currently in the process of reviewing and updating its estimates.

History. When Medi-Cal began in 1966-67 it was on an accrual accounting basis. That lasted until 1971-72 when the first shift to cash accounting was made by then Governor Ronald Reagan. That switch was made, in part, to help address a budget deficit problem similar to that which exists today.

Medi-Cal remained on a cash basis for 20 years until '91-'92 when then Governor Pete Wilson switched to an accrual basis. Again, the switch was made to address a budget deficit situation. However, this time it was done in the context of a much greater change to count all state revenue sources on an accrued basis, as well. The increased revenues that would be gained from their accrual substantially offset the increased costs of moving Medi-Cal to an accrual basis.

It was also argued that in order to count the revenue on an accrual basis, all state programs should be on the same basis. On the other hand, the federal government requires Medi-Cal (Medicaid) to be accounted on a cash basis. Therefore, DHS has had to maintain two separate sets of accounting books for the Medi-Cal program ever since the change was made in '91-'92.

One other major concern led to the shift to accrual and that was that the bond rating agencies were concerned that the state was incurring debt without an approved budget, when Medi-Cal deficiencies took place. At that time there were deficiencies almost every year and they automatically became an obligation that Medi-Cal had to pay. Now, under Section 16531.1, as proposed to be amended, there would be a mechanism already in place to pay for such deficits.

COMMENTS

1. ***Is shifting Medi-Cal from accrual to cash just an accounting gimmick?*** Yes some could call it that, but in reality it reduces the amount of money that has to be appropriated for Medi-Cal in the year the change is made by $1.2 billion General Fund, or more, thereby reducing the overall deficit by the same amount. This reduction is one-time and will only effect the year in which the change is made. Again, it is simply a way to eliminate the need to increase revenues or cut costs by an additional $1.2 billion General Fund.

2. ***What is the justification for changing to cash?*** First, the federal government requires Medi-Cal to be on a cash basis and the change would eliminate the

need to keep two separate sets of books for Medi-Cal. Second, there is no overriding requirement for accrual and it would simplify DHS's fiscal forecasting and accounting procedures. Third, it will avoid the need to cut programs or increase revenues by $1.2 billion, or more.

3. ***Should the shift to cash be made without providing the loan authority to cover deficits?*** Absolutely not. Existing law is designed to continue Medi-Cal payments to providers in the absence of a budget, and this provision has to be extended to apply to budget deficits too. Otherwise we would only be opening the door to the deficit funding problems of the past and that should be avoided at all costs. No one should want to reopen the issue of cutting off payments to providers. The extended loan authority would also counter the concerns previously raised by the bond rating agencies.

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Review prepared by:
George Cate, Senate Appropriations Committee
Diane Van Maren, Senate Budget and Fiscal Review Committee
Laurel Mildred, Senate Office of Research